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Research Brief

Barriers to Dental Care Among Adult Medicaid Beneficiaries: A Comprehensive Analysis in Eight States

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Key Messages

- *A survey of dentists and Medicaid beneficiaries in eight states indicates that underutilization of dental services among beneficiaries and low participation in Medicaid among dentists stem from several shared barriers: lack of comprehensive dental coverage for adults under Medicaid, which leads to prohibitive out-of-pocket costs, and difficulty finding a Medicaid-participating dentist.*
- *To improve dental care utilization among beneficiaries and access to care, state Medicaid programs need to enhance coverage and provide more dental care navigation tools to beneficiaries. To enhance provider participation, Medicaid programs need to increase reimbursement and ease administrative burdens. Expanding coverage will also increase provider participation.*

Introduction

Poor oral health has serious implications for one's overall health, self-esteem, and productivity. Inflammation of the oral cavity can lead to or exacerbate pregnancy complications and chronic conditions such as diabetes and heart disease.[1] Insecurity with the appearance of one's mouth make some hesitant to interview for a job or engage in social activities.[2] Pain and other complications caused by oral disease cause productivity losses among workers and students and cost the U.S. economy $46 billion annually.[3]

The medical, social and economic burden of oral disease disproportionately impacts low-income populations, some racial/ethnic minorities, people in rural areas, and seniors.[4] Disparities in oral health outcomes,[5] dental care utilization,[6] and cost barriers to care[6] persist among these groups despite more than a decade of Medicaid expansions in most states.

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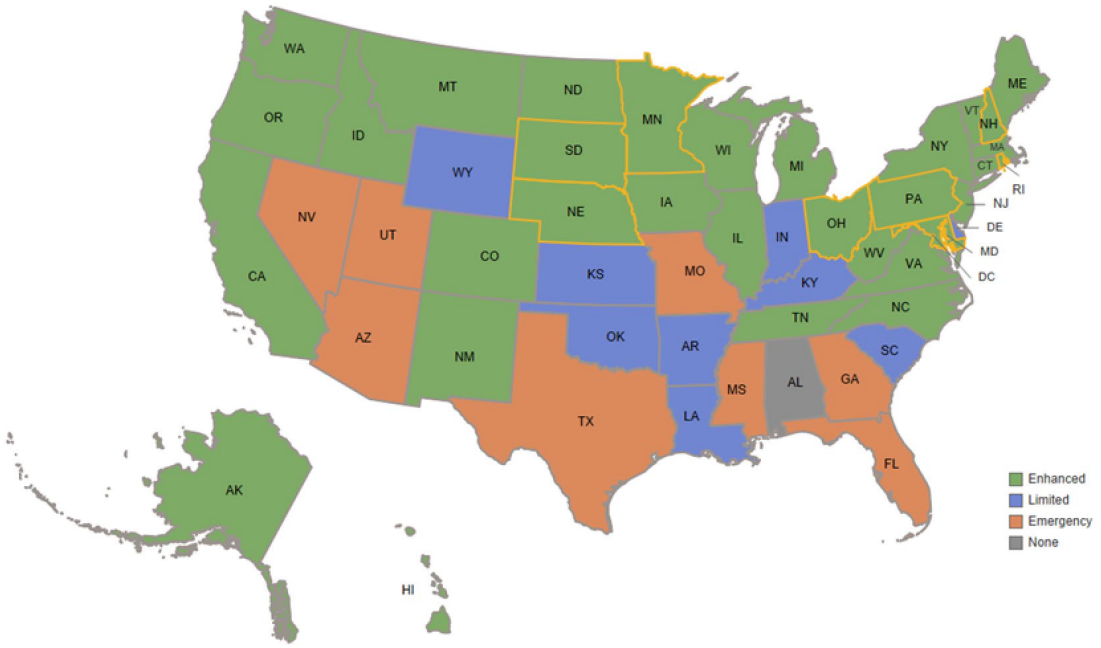
Health policy at the state and federal levels has taken a fragmented approach to oral health, leaving low-income adults without a safety net to obtain needed dental care. As of 2021, less than one-fifth of working-age adults at or under 100 percent of the federal poverty level have been to the dentist in the past twelve months.[6] Dental benefits for adults are optional under state Medicaid programs, with several states only offering limited or emergency only benefits (Figure 1). In April 2024, the Biden administration granted states the option of adding routine adult dental care as an essential health benefit (EHB); under the Affordable Care Act (ACA), only pediatric dental benefits qualified as an EHB.[7] While this change at the federal level is a positive step, adding adult dental care as an EHB will not be enough to address a host of dental care access issues that vulnerable groups face, especially since states can still opt not to include adult dental care as an EHB.[7] In the meantime, too many low-income adults have inadequate dental benefits coverage or are at risk of losing what coverage they have due to Medicaid eligibility changes.[8] Around 16 percent of working-age adults are covered by public programs such as Medicare and Medicaid and another 23 percent are uninsured.[6] For adults in rural areas, more than one-third are uninsured.[9] In states that do offer adult dental coverage in their Medicaid programs, limited number of procedures covered,[10] out-of-pocket expenditures,[11] and spending caps may still cut off access to needed dental care. Even in states with an extensive dental benefit for adults, the utilization rate among working-age adults is, at most, 34 percent.[12]

In addition to limited dental benefits coverage, access to care is also hindered by low dentist participation in public programs. In every state, there is a segment of dentists who are enrolled as Medicaid providers but did not have any Medicaid claims in the past year, meaning they did not treat any Medicaid beneficiaries.[13] In some states, treatment of Medicaid beneficiaries largely falls to a small segment of the dentist workforce, indicating that the geographical location and appointment availability of Medicaid dentists is very limited. While expanding benefits coverage under Medicaid is important for increasing dental care access, it may not be enough to entice dentists to participate, especially if providers' top pain points surrounding Medicaid – low reimbursement and administrative burdens – are not remedied in policy reforms.

Addressing oral health disparities depends in part on addressing shortcomings in the Medicaid program for both beneficiaries and providers. To assess the range of barriers preventing (1) Medicaid beneficiaries from receiving dental care and achieving optimal oral health and (2) dentists from participating in their state's Medicaid program, we conducted surveys of beneficiaries and dental providers in eight states. This paper summarizes the results of these surveys and outlines policy considerations for the future.

Figure 1: Adult Medicaid Dental Benefit Level by State



Source: Health Policy Institute analysis of data from state Medicaid websites and the CareQuest Medicaid Adult Dental Coverage Tracker.[14] Analysis based on data as of mid-2024. **Note:** None = No coverage. Emergency-only = Coverage for pain relief under defined emergency situations. Limited = Coverage for a subset of diagnostic, preventive, and minor restorative procedures with a per-enrollee annual maximum expenditure of $1,000 or less. Enhanced = Coverage for a more comprehensive mix of services, including at least diagnostic, preventive, and restorative procedures, and a per-enrollee annual maximum expenditure of at least $1,000 or no annual spending limit. States outlined in yellow were the eight states selected for the beneficiary and dentist surveys.

Project Background and Methods

As part of the American Dental Association's (ADA) public program advocacy efforts, HPI and the Medicaid Advisory Committee (MAC) led a joint effort to survey Medicaid beneficiaries and dentists in six "pilot" states with the goal of increasing dentist participation in Medicaid and beneficiary utilization of dental services. The survey results may be used to inform materials in advocacy toolkits for state dental associations, health departments, and other organizations to set specific goals and strategies surrounding provider participation in Medicaid.

At the conclusion of this project, the ADA will release a comprehensive report on the successes, strategies, and outcomes from these six states. The overarching goal of the pilot project is to increase the number of dentists with claims for Medicaid beneficiaries by 5 to 10 percent and the number of dentists with claims for more than 100 Medicaid beneficiaries by 5 to 10 percent. ADA will then measure increased access to care and utilization among Medicaid beneficiaries by category of dental service type. Each state will determine their own specific goals.

The six pilot states include Maryland, Nebraska, Ohio, Pennsylvania, Rhode Island, and South Dakota. These states were selected on the basis of their differing

Medicaid programs and other factors (i.e., number of managed care organizations (MCOs), robustness of oral health services and Medicaid coverage, potential or recently implemented fee increases, differing demographics of the oral health workforce, proximity to a dental school, etc.). HPI added two additional states – Minnesota and New Hampshire – for more robust results.

HPI conducted two online surveys to gather data from adult (aged 18 to 64) Medicaid beneficiaries and dentists. HPI commissioned Qualtrics to manage data collection for the survey of Medicaid beneficiaries, which ran from December 4, 2023 to January 11, 2024. HPI staff managed data collection for the survey of dentists, which ran from December 2 to December 30, 2023.

The Survey of Medicaid Beneficiaries was administered using nonprobability-based sampling. Respondents were recruited from Qualtrics' online panel partners. Respondents who indicated that they are enrolled in their state's Medicaid program were invited to complete the survey. Quotas were set at 300 responses per state (or best effort). A total of 2,467 Medicaid beneficiaries responded with a +/- 6% margin of error for each state.

The instrument for the beneficiary survey, developed by HPI staff, consisted of seven questions related to oral health: (1) respondents' oral health status at the time of the survey, (2) how often respondents experienced specific oral health problems (items taken from the Oral Health Impact Profile-5[15]), (3) how often respondents practiced specific oral health habits at home, (4) the timing of respondents' last dental visit, (5) reasons respondents do not go to the dentist more often, (6) respondents' agreement with attitudes and beliefs about oral health and visiting the dentist (some items taken from the Oral Health Values Scale[16]), and (7) respondents' thoughts on oral health options offered by Medicaid (an open-ended question).

The Survey of Dentist Opinions on Medicaid was administered to all 18,886 full and part-time dentists in the eight states with a valid email address in the ADA masterfile. Respondents who confirmed that they work in one of the eight states were invited to complete the survey. Due to the low number of responses from dentists practicing in Rhode Island, South Dakota and New Hampshire, results should be interpreted with caution.

The instrument for the dentist survey, developed by HPI staff with input from the MAC, consisted of five questions. Respondents were asked to (1) report whether they participate in their state's Medicaid program, (2) report the percentage (if any) of their patient volume that is composed of Medicaid beneficiaries, (3) rate the importance of particular barriers to their Medicaid participation, (4) rate their agreement with statements about treating Medicaid beneficiaries, and (5) describe their practice capacity and whether practice capacity is affected by staffing shortages. A total of 999 dentists responded. Results are broken out by Medicaid participation status: dentists who have and have not treated any Medicaid beneficiaries in the last 12 months.

For context, we were able to gain insights on the representativeness of our sample – both adult Medicaid beneficiaries and providers – by comparing survey results to administrative data. For example, we compared dental care utilization rates among our sample of adult Medicaid beneficiaries against administrative claims data (Table 1). [17] It is important to note that the administrative data still likely underestimate the true utilization rate as they do not accurately capture federally qualified health center (FQHC) and public health clinic visits. Still, the data suggest that our sample is skewed toward adult Medicaid beneficiaries who are more likely to visit a dentist.

Table 1: Adult Medicaid Dental Utilization Rates, Survey Results vs. Claims Data

	Medicaid Adult Dental Utilization Rate – Survey Results	Medicaid Adult Dental Utilization Rate – Claims Data
Maryland	49%	11%
Minnesota	52%	29%
Nebraska	39%	22%
New Hampshire	53%	6%
Ohio	44%	24%
Pennsylvania	41%	23%
Rhode Island	59%	18%
South Dakota	54%	22%

Source: For the survey results column: HPI Survey of Medicaid Beneficiaries in Eight States. For the claims data column: HPI analysis of the Center for Medicare and Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS)).[17] **Notes**: Percentages for both the survey results data and the administrative claims data indicate the percentage of the Medicaid adult population that had at least one dental visit in the past 12 months. Results from the survey are for 2023; results from the claims data are for 2021.

Similarly, comparing the percent of dentists in our sample who report they currently see Medicaid beneficiaries (whether children or adults) with administrative data gives insights on provider representativeness. [18] Based on this comparison, our sample of dentists appears to be skewed toward providers that are more likely to participate in Medicaid (Table 2).

Table 2: Dentist Participation Rates in Medicaid, Survey Results vs. Claims Data

	Dentist Participation in Medicaid – Survey Results	Dentist Participation in Medicaid – Claims Data
Maryland	55%	28%
Minnesota	74%	N/A
Nebraska	69%	N/A
New Hampshire	67%	13%
Ohio	52%	29%
Pennsylvania	51%	N/A
Rhode Island	50%	25%
South Dakota	87%	N/A

Source: For the survey results column: HPI Survey of Dentist Opinions on Medicaid in Eight States. For the claims data column: HPI analysis of ADA office database and data from the Center for Medicare and Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS)).[18] **Notes**: Data for Minnesota, Nebraska, Pennsylvania, and South Dakota were excluded from HPI's 2021 analysis due to high rates of missing claims data. Data for T-MSIS represents dentists any Medicaid claims in the past 12 months (whether for child or adult beneficiaries).

Results

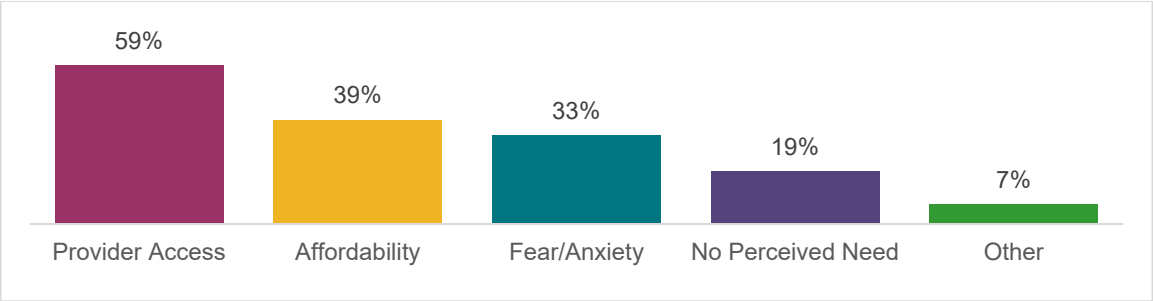
Results for the surveys of Medicaid beneficiaries and dentists are available in full in separate reports – one report with results for all eight states in aggregate as well as individual reports for each state (see the end of this paper for links to all of the reports). This paper focuses on barriers to dental care among adult Medicaid beneficiaries and barriers to Medicaid participation among dentists for all eight states.

Adult Medicaid beneficiaries responding to the survey were asked about the timing of their last dental visit; 49 percent of respondents reported that they have visited the dentist in the past 12 months. Respondents who have not been to a dentist in the past 12 months were asked why they do not visit the dentist more often. The barriers to dental care fall under five categories: provider access, affordability, fear/anxiety, no perceived need, and other. The top barrier category among survey respondents was provider access, with

around three out of five beneficiaries citing various accessibility issues as the reason why they do not visit the dentist more frequently (Figure 2).

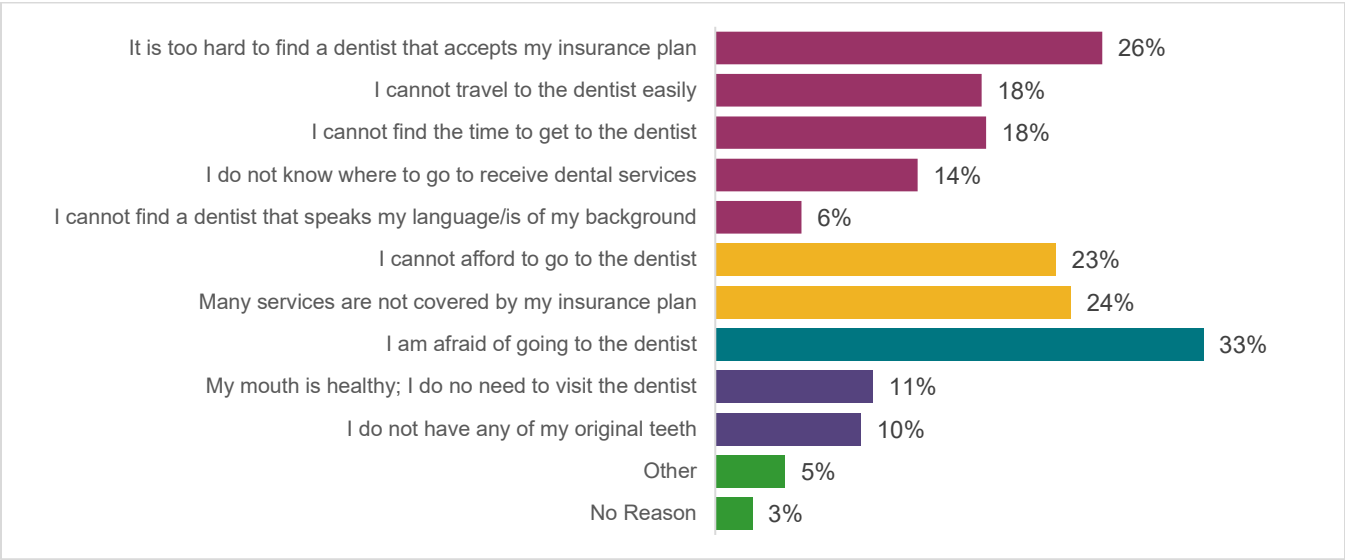
The most prominent provider access issue was difficulty finding a dentist that accepts beneficiaries' insurance plan (i.e., Medicaid), followed by inability to find the time and means to travel to the dentist (Figure 3). The biggest issue under affordability – the second most prominent barrier category – was not enough procedures covered under Medicaid. Around one-third of respondents cited fear and anxiety as a barrier to dental care, as well.

Figure 2: Reasons for Not Visiting the Dentist More Frequently Among Adult Medicaid Beneficiaries



Notes: Results are for Adult Medicaid beneficiaries in all eight states (MD, MN, NE, NH, OH, PA, RI, SD) combined who reported that they have **not** been to the dentist in the past 12 months. Percent indicates share of respondents reporting a specific barrier to dental care. Percentages do not add to 100% due to multiple options being selected.

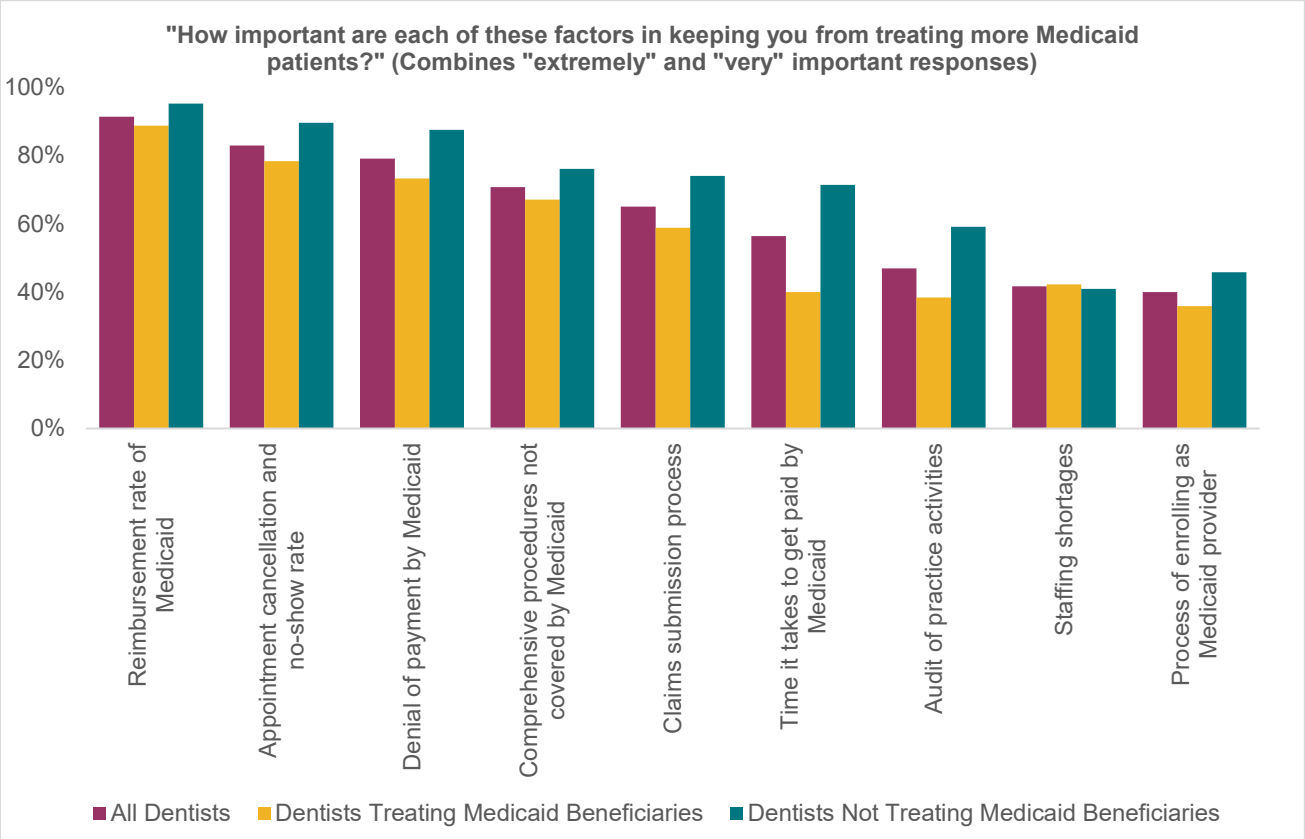
Figure 3: Reasons for Not Visiting the Dentist More Frequently Among Adult Medicaid Beneficiaries, Individual Items by Category



Notes: Results are for Adult Medicaid beneficiaries in all eight states (MD, MN, NE, NH, OH, PA, RI, SD) combined who reported that they have **not** been to the dentist in the past 12 months. Percent indicates share of respondents reporting a specific barrier to dental care. The bars in this graph correspond with the general categories outlined in Figure 2. The purple bars are barriers that fall under "provider access," the yellow bars are barriers that fall under "affordability," the purple bars are barriers that fall under "no perceived need," and the green bars fall are barriers that fall under "other."

The barriers to dental care identified by adult Medicaid beneficiaries such as difficulty finding a dentist who accepts Medicaid and not enough procedures being covered are mirrored partly by the barriers to Medicaid participation cited by dentists. More than half of responding dentists across the eight states (59 percent) reported that they treat Medicaid beneficiaries (whether children or adults), with Medicaid beneficiaries accounting for an average of 37 percent of participating dentists' patient volume. Dentists were then asked why they do not participate in their Medicaid program – either at all, or to a larger extent by treating more Medicaid beneficiaries. For all dentists, the top barrier was reimbursement – more than nine out of ten dentists cited it as a very or extremely important factor (Figure 4). The second largest barrier was the appointment cancellation and no-show rate of Medicaid beneficiaries, cited by more than eight out of ten dentists as very or extremely important. Other barriers to Medicaid participation include denied and delayed reimbursement, not enough procedures covered under Medicaid, audit of practice activities, staffing shortages, and cumbersome claims submission and enrollment processes. For most of these factors, dentists who do *not* treat Medicaid beneficiaries were more likely to say these were extremely or very important factors compared to dentists currently treating Medicaid beneficiaries.

Figure 4: Importance of Barriers to Treating Medicaid Beneficiaries Among Dentists

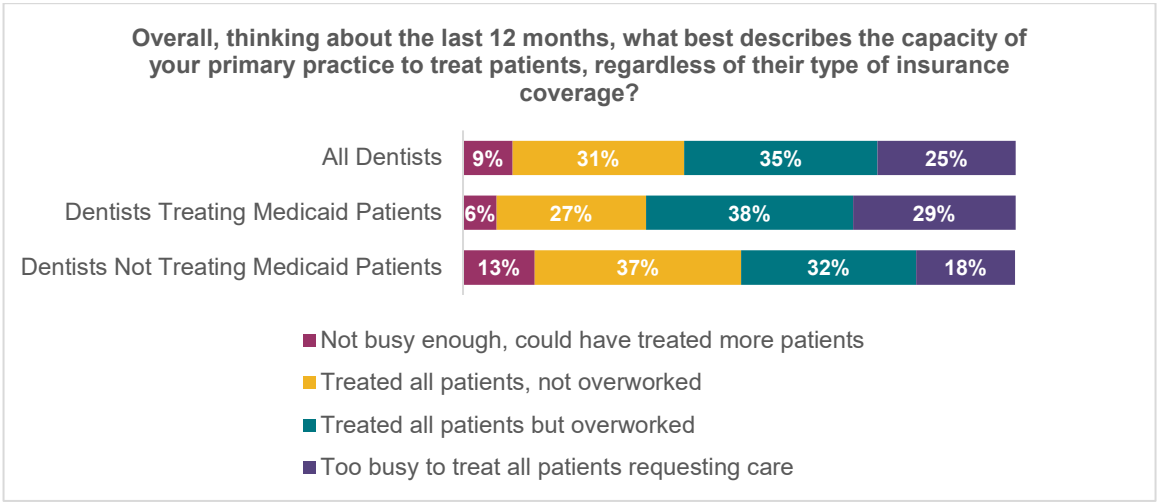


Notes: Results are for dentists in all eight states (MD, MN, NE, NH, OH, PA, RI, SD) combined. Results combine "extremely" and "very important" responses.

While there was little difference between dentists treating Medicaid beneficiaries and dentists not treating Medicaid beneficiaries in terms of citing staffing shortages as a barrier to participating in Medicaid, another question in the survey revealed key differences in busyness levels between the two groups of providers. When asked about their practice capacity, nearly two-thirds of dentists (64 percent) currently treating Medicaid patients reported that in the past 12 months they were either too busy to treat all patients requesting care or that they treated all patients but were overworked compared to half of dentists currently *not* treating Medicaid beneficiaries (Figure 5). Medicaid providers are busier than dentists who do not see Medicaid patients.

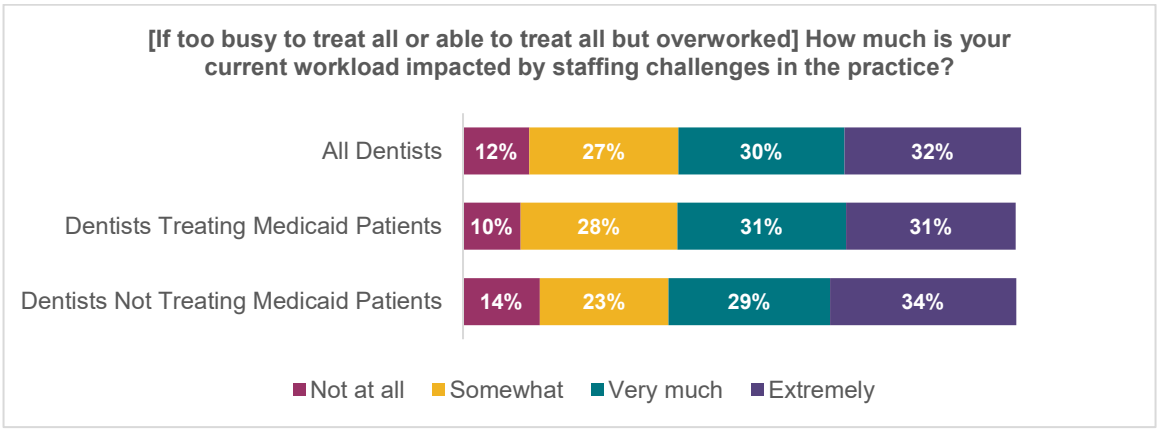
Dentists who reported that they were too busy in the past 12 months were asked if their workload was impacted by staffing shortages in their practice. There are less marked differences in impact of staffing shortages between dentists treating and not treating Medicaid beneficiaries (Figure 6). Staffing shortages are quite pervasive across provider types.

Figure 5: Busyness Levels Among Dentists



Notes: Results are for dentists in all eight states (MD, MN, NE, NH, OH, PA, RI, SD) combined.

Figure 6: Staffing Challenges Among Dentists



Notes: Results are for dentists in all eight states (MD, MN, NE, NH, OH, PA, RI, SD) combined.

Discussion

Based on the survey results, there are a number of program-level issues identified by both Medicaid beneficiaries and providers. For example, lack of comprehensive services is a top affordability barrier for beneficiaries, with 24 percent citing it as a reason why they do not go to the dentist more often; in response to another survey question (results not depicted in this paper), 22 percent of all beneficiaries agreed or strongly agreed that going to the dentist is not worth the cost. Seven out of ten dentists rated lack of comprehensive procedures covered by Medicaid as extremely or very important to why they do not participate in Medicaid (either more or at all).

Meanwhile, low reimbursement is the top barrier to Medicaid participation among all dentists, particularly those not currently treating Medicaid beneficiaries. Time it takes to get reimbursed by Medicaid is another top barrier. More than 4 out of 5 dentists agreed or strongly agreed that low reimbursement from Medicaid would harm their practice's profitability. Clearly, Medicaid coverage is not robust enough to prevent prohibitive out-of-pocket expenses for beneficiaries and to allow providers to provide extensive treatment, which, in turn, maintains practice profitability for dentists.

Difficulty for beneficiaries to find Medicaid providers and difficulty for providers to enroll in Medicaid are also twin issues. Two out of 5 dentists said that the process of enrolling as a Medicaid provider is an extremely or very important barrier to participation, and more than one-quarter of beneficiaries who have not been to the dentist in the past 12 months said it is too difficult to find a participating dentist.

There are also program-level issues where Medicaid beneficiaries and providers have differing perspectives. Thirty-nine percent of dentists disagree or strongly disagree that Medicaid beneficiaries value their oral health, 50 percent disagree or strongly disagree that Medicaid beneficiaries comply with treatment plans, and 41 percent agree or strongly agree that Medicaid beneficiaries are culturally more difficult to treat. However, this is in stark contrast to what Medicaid beneficiaries report, with 80 percent agreeing or strongly agreeing that their oral health is important to their overall health, while 78 percent agree or strongly agree that their mouth is an important part of their appearance. There is a stark patient-provider divide when it comes to beliefs about the value of oral health.

Dentists also take issue with the no-show and appointment cancellation rate among Medicaid beneficiaries – it's the second biggest barrier to Medicaid participation, with 83 percent of dentists rating it as very or extremely important. However, the no-show rate may stem from several barriers on the beneficiary side that dentists may underestimate or underappreciate. Fear of going to the dentist was cited by one-third of beneficiaries who had not been to the dentist in the past 12 months. A significant share of beneficiaries also cited challenges with traveling to the dentist and finding a convenient appointment time, and some cited difficulty finding a provider who speaks their language. There is a clear patient-provider divide about the underlying driver of no-shows and cancellations.

Policy Implications

Based on insights provided by beneficiaries and providers alike, there are several policy reforms required to reduce the friction between Medicaid beneficiaries and the dental care they need. First and foremost, policymakers ought to fix dental coverage gaps for adults in Medicaid. Beneficiaries need comprehensive coverage that includes both preventive and restorative dental care. Studies indicate adults with public insurance have lower shares of preventive care

and higher shares of invasive surgical procedures compared to adults with private insurance, including in states that already have an extensive adult dental benefit under Medicaid.[19] Medicaid enrollees with no preventive visits are eight times more likely to have treatment in an emergency department compared to those who had preventive visits.[20] Clearly, there is a need for much more routine, preventive dental care utilization among Medicaid adults. But our study also shows the need for coverage of comprehensive, restorative services. Adult Medicaid beneficiaries see the lack of comprehensive coverage as a major barrier to care as it leads to unexpected and potentially prohibitive out-of-pocket costs.

Second, policymakers ought to reduce administrative hurdles for providers. Since the pandemic, more than one-third of U.S. dentists feel overworked and unable to treat all patients requesting care.[21] Some dentists report that they are increasingly performing more duties normally covered by hygienists, assistants, and administrative staff, preventing them from focusing on clinical care.[22] As the survey results for this report indicate, dentists who participate in Medicaid feel more overworked than dentists who do not. Busyness levels and staffing challenges leave dentists with little time or inclination to deal with audits, cumbersome enrollment processes, denial of claims, and delayed reimbursement in their states' Medicaid programs. A study of new dentists (those who graduated from dental school less than 10 years ago) found that dentists highly value balance of clinical and non-clinical duties and clinical autonomy.[23]

Third, low reimbursement rates for dental care services must be addressed. Both dentists currently treating Medicaid patients and those not treating Medicaid patients noted reimbursement rates of Medicaid as the top reason for not treating more Medicaid patients. Low reimbursement rates limit the number of Medicaid patients that dentists can feasibly treat and may be the main barrier to participating in the Medicaid program for some dentists. Finding a dental provider that accepts their insurance plan was the top barrier to dental care utilization cited among provider access issues reported by beneficiaries, followed by affordability. When dentists cannot afford to treat Medicaid beneficiaries, the cost of treatment gets passed along to patients. In fact, nearly one-quarter of beneficiaries reported that because certain services were not covered under their insurance plan, they ended up having to pay with their own money. All eight states in this study are categorized as having "enhanced" dental coverage for adult Medicaid beneficiaries as of 2023 (Figure 1). However, between 26 to 54 percent of beneficiaries in all eight of these states reported that they faced affordability barriers to dental care. Policymakers, dentists, and beneficiaries may need to come together to redefine what constitutes a comprehensive dental benefit to alleviate financial difficulties for providers and patients alike.

Fourth, while increasing provider participation in Medicaid is important, easier ways are needed to connect beneficiaries to a dental home. Finding a Medicaid dentist who is accepting new patients, has a convenient location and appointment times, and speaks the desired language can be difficult, as the survey results indicate. State Medicaid programs could collaborate with various partners to develop cutting edge navigation tools such as OpenTable-style models for easy appointment booking. These tools should include some type of subsidized transportation service, such as Uber Health or Lyft Healthcare. Such tools would likely decrease no-show rates and help ease some of the frustrations expressed by providers, who see no-shows and cancellations as a sign of disrespect, not realizing that beneficiaries may be struggling to secure transportation or leave their hourly jobs.[24] Dental offices can also reconsider penalties for

missing appointments such as late fees and patient dismissal policies; while these policies apply to all patients regardless of insurance type, the policies can be particularly alienating to vulnerable populations who already struggle with navigating and trusting the health care system.[24,25]

Fifth, policymakers ought to consider ways to enhance oral health literacy. While Medicaid beneficiaries value their oral health, survey results indicate that their at-home oral health habits and oral health literacy could improve. Oral health literacy campaigns can specifically target sugar consumption, tobacco usage, and oral hygiene. Patients' struggles with fear and anxiety regarding visiting the dentist – another significant barrier to dental care – can be addressed through accessible mental health services such as tools that offer cognitive behavioral therapy (CBT) to address dental-related fears.[26]

Making improvements to Medicaid programs through increased reimbursement, expanded coverage, and reduced administrative burdens may not entirely solve ongoing disparities in oral health. Survey results indicate poor oral health literacy among beneficiaries and negative provider perceptions of Medicaid participation are as much political, cultural, and social issues as they are economic or administrative ones. Negative views of Medicaid can stigmatize both beneficiaries and the providers who accept it.[27,28] Around one-fifth of dentists responding to the survey agreed or strongly agreed that being a Medicaid-enrolled provider negatively affects their reputation among their professional peers. While some public opinion polls indicate positive views of Medicaid,[29] there may need to be societal changes in the way the program is viewed. Reorienting attitudes around Medicaid will require joint efforts by health policy research groups, government organizations, provider networks, patient advocacy groups, political leaders at all levels, and average citizens.

The ADA remains committed to supporting provider participation in and beneficiary utilization of dental services under Medicaid. At the conclusion of the Pilot Project in 2025, more resources will be released for further policy advancements and improvements.

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References

[1] Kane SF. The effects of oral health on systemic health. *Gen Dent*. 2017;65(6):30-34.

[2] American Dental Association. Oral health and well-being in the United States. Health Policy Institute. Infographic. 2016. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf. Accessed May 10, 2024.

[3] Centers for Disease Control and Prevention. Health and economic benefits of oral disease interventions. April 15, 2024. Available from: https://www.cdc.gov/nccdphp/priorities/oral-disease.html?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/programs-impact/pop/oral-disease.htm. Accessed May 24, 2024.

[4] U.S. Department of Health and Human Services. 2020 Surgeon General's report oral health in America: advances and challenges. National Institute of Dental and Craniofacial Research. 2021. Available from: https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf#page=59. Accessed May 24, 2024.

[5] Bashir NZ. Update on the prevalence of untreated caries in the US adult population, 2017-2020. *JADA*. 2021;153(4):300-308.

[6] American Dental Association. National trends in dental care use, dental insurance coverage, and cost barriers. Health Policy Institute. November 2023 (updated March 2024). Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/national_trends_dental_use_benefits_barriers.pdf. Accessed May 10, 2024.

[7] CMS.gov. HHS Finalizes Policies to Make Marketplace Coverage More Accessible and Expand Essential Health Benefits. April 2, 2024. Available from: https://www.hhs.gov/about/news/2024/04/02/hhs-finalizes-policies-make-marketplace-coverage-more-accessible-expand-essential-health-benefits.html. Accessed May 24, 2024.

[8] Burroughs M, Wilson K, Matson M. New ACA policy expands access to dental care. Now, states need to act. *Health Affairs Forefront*. May 8, 2024. DOI: 10.1377/forefront.20240507.479279.

[9] CareQuest Institute for Oral Health. 2023 State of Oral Health Equity in America. 2024. Available from: https://www.carequest.org/content/state-oral-health-equity-america-2023. Accessed May 24, 2024.

[10] MACPAC. Medicaid coverage of adult dental services. Issue brief. January 2021. Available from: https://www.macpac.gov/wp-content/uploads/2021/01/Medicaid-Coverage-of-Adult-Dental-Services.pdf. Accessed June 17, 2024.

[11] Halasa-Rappel YA, Brow A, Tranby EP, Frantsve-Hawley J. Poor families spent 10 times more of their income on dental care than wealthier families. CareQuest Institute for Oral Health. September 2019. Available from: https://www.carequest.org/system/files/CareQuest-Institute-Poor-Families-Spend-10-Times-More-Brief-Part1.pdf. Accessed June 13, 2024.

[12] Williams E, Rudowitz R. Variation in use of dental services by children and adults enrolled in Medicaid or CHIP. Kaiser Family Foundations. May 29, 2024. Available from: https://www.kff.org/medicaid/issue-brief/variation-in-use-of-dental-services-by-children-and-adults-enrolled-in-medicaid-or-chip/#:~:text=Rates%20of%20dental%20service%20use%20among%20Medicaid%20adults%20are%20higher,%2C%20Massachusetts%2C%20and%20New%20Jersey. Accessed June 13, 2024.

[13] Vujicic M, Nasseh K, Fosse C. Dentist participation in Medicaid: how should it be measured? Does it matter? American Dental Association. Health Policy Institute Research Brief. October 2021. Available from: Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf. Accessed August 13, 2024.

[14] CareQuest Institute for Oral Health. Medicaid adult dental benefit expansion. 2024. Available from: https://www.carequest.org/Medicaid-Adult-Dental-Coverage-Checker. Accessed August 7, 2024.

[15] Naik A, John MT, Kohli N, Self K, Flynn P. (2016). Validation of the English-language version of 5-item Oral Health Impact Profile. *J Prosthodont Research*. 2016;60(2):85-91.

[16] Edwards CB, Randall C, McNeil DW. Development and validation of the Oral Health Values Scale. *Comm Dent Oral Epidemiol*. 2021;49(5):454-463.

[17] This figure of adult dental care utilization under Medicaid collected by our survey of beneficiaries in eight states is higher than the percentage reported by the Centers for Medicare and Medicaid's Transformed Medicaid Statistical Information System (T-MSIS) data. This discrepancy may be due to survey response bias (e.g., Medicaid beneficiaries who have visited the dentist in the last year may have been more likely to respond.) See HPI's Dental Care Utilization dashboard for utilization rates as of 2021, available from: https://www.ada.org/resources/research/health-policy-institute/child-dental-care-utilization-dashboard. Accessed August 13, 2024.

[18] Vujicic M, Nasseh K, Fosse C. Dentist Participation in Medicaid: How Should It be Measured? Does It Matter? American Dental Association. Health Policy Institute Research Brief. October 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf. Accessed August 13, 2024.

[19] Nasseh K, Fosse C, Vujicic M. Comparative analysis of dental procedure mix in public and private dental benefits programs. *JADA*. 2021;153(1):59-66.

[20] Okunev I, Tranby EP, Jacob M, et al. The impact of underutilization of preventive dental care by adult Medicaid participants. *J Pub Health Dent*. 2022;82(1):88-98.

[21] American Dental Association. Dentist earnings and busyness. Health Policy Institute. Available from: https://www.ada.org/resources/research/health-policy-institute/dental-practice-research/2023-us-dental-practice-trends. Accessed June 19, 2024.

[22] American Dental Association. Economic Outlook and Emerging Issues in Dentistry: insights from data from October 2023. Health Policy Institute. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/oct2023_hpi_economic_outlook_dentistry_slides.pdf. Accessed June 19, 2024.

[23] Vujicic M, Starkel Weninger R, Harrison B, Nasseh K. Practice setting transitions and career satisfaction among new dentists. American Dental Association. Health Policy Institute. Research brief. July 2023. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_practice_transitions_new_dentists.pdf. ccessed June 19, 2024.

[24] Canares G. Patient late policies need a diversity, equity, and inclusion refresh. *JADA*. 2024;155(3):193-194.

[25] Duke CC, Stanik C. Overcoming lower-income patients' concerns about trust and respect from providers. *Health Affairs Forefront*. August 11, 2016. Available from: https://www.healthaffairs.org/content/forefront/overcoming-lower-income-patients-concerns-trust-and-respect-providers#:~:text=Participants%20felt%20they%20were%20treated,strongly%20associated%20with%20poor%20health. Accessed June 19, 2024.

[26] Harrison R. Overcoming dental fear with the tap of an app. New York University. March 7, 2024. Available from: https://www.nyu.edu/about/news-publications/news/2024/february/dental-fear.html. Accessed June 19, 2024.

[27] Ng S. Stigma and Medicaid: a struggle for health equity. The Healthcare Review at Cornell University. December 12, 2021. Available from: https://www.cornellhealthcarereview.org/post/stigma-and-medicaid-a-struggle-for-health-equity. Accessed June 19, 2024.

[28] Michener J. People who get Medicaid are made to feel powerless. That pushes them out of politics and toward fatalism. *The Washington Post*. August 17, 2017. Available from: https://www.washingtonpost.com/news/monkey-cage/wp/2017/08/17/people-who-get-medicaid-are-made-to-feel-powerless-that-pushes-them-out-of-politics-and-toward-fatalism/. Accessed June 19, 2024.

[29] Kaiser Family Foundation. 5 charts about public opinion on Medicaid. March 30, 2023. Available from: https://www.kff.org/medicaid/poll-finding/5-charts-about-public-opinion-on-medicaid/. Accessed June 19, 2024.

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Access the **full report of all eight states in aggregate** and complete list of survey items for Survey of Medicaid Beneficiaries and Survey of Dentist Opinions on Medicaid: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/Survey_Dentists_Medicaid_Beneficiaries_Eight_States.pdf.

For **individual state reports**:

- **Maryland**: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/survey_dentists_Medicaid_beneficiaries_Maryland.pdf.
- **Minnesota**: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/survey_dentists_Medicaid_beneficiaries_Minnesota.pdf.
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